KHBE-79
Rev: 12/1/13

Authorized Representative Form

_____ _____
Name Date of Birth

Type of Request:

- o Add New Representative.
- o Change Duties of Current Representative
- o Cancel Current Representative as of _____

You may choose an authorized representative to help you with some or all of enrollment for health coverage or other benefits. These benefits include: health insurance plans, premium assistance, special discounts, Medicaid, or KCHIP.

An authorized representative is a friend, relative, or other person who has a concern for your well-being. An authorized representative is a person you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an authorized representative, but a person at an agency can.

An authorized representative may fill out an application and do other paperwork for you. They may also report changes to your income and other life changes for you. They may request an appeal for you.

Tell us your authorized representative's name, address, and telephone number. Please print clearly.

_____ _____ _____
First Name Middle Initial Last Name

_____ _____
Street/Mailing Address Phone Number

_____ _____
City, State, and Zip Code Other Phone Number

_____
Your relationship to Authorized Representative

(If your authorized representative is a member of an agency, include the name of the agency here. _____

Check the things you want the authorized representative to do for you.

- ○ Sign an application on my behalf
- ○ Submit an update or respond to a redetermination of eligibility on my behalf
- ○ Complete and submit a renewal form
- ○ Receive copies of notices and other communication from the Kentucky Health Benefit Exchange
- ○ Request an appeal on my behalf
- ○ Act on my behalf in an appeal
- ○ Act on my behalf in issues that affect my eligibility to enroll in health coverage with the Kentucky Health Benefit Exchange

To Be Completed by Authorized Representative

I hereby accept the above appointment and understand that:

- The applicant may cancel this authorization at any time and choose another individual as his/her authorized representative
- I have no other power to act on behalf of the applicant, except as stated above;
- I may not pass on my appointment to another person
- I am responsible along with the applicant for any incorrect or incomplete information I provide
- I can cancel this appointment by giving written notice.

I agree to maintain the confidentiality of any information regarding the applicant provided by the Cabinet for Health and Family Services.

_____

Signature of Authorized Representative

Signature of Applicant

I, _____, have read and understand the contents of this form. I understand that by signing this form, I am authorizing _____to act on my behalf as described above.

_____ _____

Applicant Signature Date

If signed by other than the applicant or parent of a minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney, legal guardianship) to make this authorization.

Authorized Representative Name: _____

Relationship to Applicant: _____